Do Not Staple!

KENTUCKY EMPLOYEES HEALTH PLAN

ENROLLMENT APPLICATION FOR THE KENTUCKY TEACHERS' RETIREMENT SYSTEM (KTRS)

PY 2009

Mail application to:

479 Versailles Road
Frankfort, KY 40601

INSURANCE COORDINATOR SECTION

__ __ / __ __ / __ __ __ __
Coverage Effective Date

8 5 0 0 0
Company Number

Reason for Application:

☐ < New Retiree ☐ < Open Enrollment ☐ < QE* ☐ < Previously Waived* ☐ < Other*

* If you previously waived, or marked "Other" or "QE" above, enter the Qualifying Event date _____ (Date) AND a description of the Qualifying Event: _____ (Qualifying Event Description)

SECTION I: DEMOGRAPHIC INFORMATION

Is retiree applying for this coverage? ☐ < Yes ☐ < No

If "No", what is your relationship to the retiree? __

__ __ __ – __ __ – __ __ __ __
RETIREE SSN *(Required)*

_____
RETIREE Name (First, MI, Last)

__ __ __ – __ __ – __ __ __ __
APPLICANT SSN (If retiree is not applying)

_____
APPLICANT Name (First, MI, Last)

RETIREE AND/OR APPLICANT Specific Information

_____
Mailing Address

__ __ / __ __ / __ __ __ __
Date of Birth (MM/DD/YYYY)

_____ _____ _____
City, State, Zip Code | County of Residence | Country / Mail Code, if not USA

_____ _____ _____
Planholder's HOME Phone Number | Planholder's Cell Phone Number | Planholder's Email Address

Smoking Status *(Required)*
Have you smoked in the last 2 months? ☐ **< Yes** ☐ **< No**

Gender
☐ < Male
☐ < Female

Marital Status
☐ < Married
☐ < Single

SECTION II: PLAN ELECTION- if waiving (i.e. decline) health insurance coverage, go to Section V.

1. Option (Check only one)
☐ < Commonwealth Standard PPO
☐ < Commonwealth Capitol Choice
☐ < Commonwealth Optimum PPO

2. Level of Coverage
☐ < Single
☐ < Parent Plus
☐ < Couple
☐ < Family

3. Cross-Reference Payment Option
(Available for Family Coverage Only)
☐ < Yes
If Yes, you must complete Sections III, IV & VII

SECTION III: SPOUSE AND/OR DEPENDENT INFORMATION → *If you elected Single coverage, skip to Section VII*

Social Security Number	Name (First, MI, Last)	Gender (Circle one)	Date of Birth (MM/DD/YYYY)	Relationship Code
		M F		
		M F		
		M F		
		M F		

Relationship Codes: SP Spouse; CH Child; DD Disabled Dependent Child; CO Court Ordered Dependent Child

SECTION IV: CROSS-REFERENCE INFORMATION → *Complete ONLY if you checked Yes in Section II, box 3*

Your Spouse's Company Number: ***(Required)***	Dual Employee Indicator, If applicable	Has your spouse smoked in the last 2 months? ***(Required)***	Is your spouse a Hazardous Duty Retiree?	Your spouses Hire Date or Retirement Date:
_____	☐ <Yes	☐ <Yes ☐ <No	☐ <Yes ☐ <No	_____

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Retiree's SSN

			–			–					

Retiree and/or Applicant's SSN (If other than retiree)

SECTION V: WAIVER

Do you wish to waive (i.e. decline) your health Insurance Coverage? ☐ < Yes

Reason for waiving _____

SECTION VI: FLEXIBLE SPENDING ACCOUNTS (FSA)

Not Applicable → Retirees are not eligible to participate in a Flexible Spending Account.

If a retiree elects the cross-reference payment option with an active spouse and the active spouse is eligible and wishes to enroll in the state's Flexible Spending Account Program, the active spouse and the retiree should make their health coverage elections by completing the active employee's Health Insurance Application.

SECTION VII: AUTHORIZATION AND CERTIFICATION

* I understand that my signature on this application creates a legal and binding contract between myself, the Department of Employee Insurance and the TPA.
* **I understand that if my spouse and I elect the cross-reference payment option, we are dual plan holders and our level of coverage (Family) will automatically drop to a parent plus coverage level upon termination of employment by either spouse/planholder. The cross-reference payment option ceases upon termination of employment by either spouse/planholder.**
* I understand that each dependent I am enrolling meets the eligibility requirements of a dependent as set forth in the plan document and in the KEHP handbook.
* I understand that this plan has a tobacco incentive for members that do not use tobacco and that this plan offers tobacco cessation programs.
* I agree to abide by the terms and conditions governing membership and receipt of services from the plan in which I have enrolled.
* I understand that the elections indicated on this application may not be changed or canceled during the plan year, with the exception of certain Qualifying Events.
* I authorize the Retirement System to deduct from my retirement benefits the amount required to cover my share of the coverage I have selected.
* I authorize the Retirement System to release the information in this application to federal and state agencies for proper administration of medical benefits. Such release of information will be made only to the extent permissible under applicable state and federal statutes. I further acknowledge that Medicare eligibility may affect my participation in the Kentucky Employees Health Plan.
* I understand that the misrepresentation of any information on this application with the intent to defraud is a fraudulent insurance act, which is a crime, and any material misrepresentation or omission may be used to reduce or deny a claim or to terminate my coverage.
* I have fully read the materials provided to me. My signature below certifies that the statements on this form are true and complete to the best of my knowledge.

_____ _____

Retiree Signature — Date

_____ _____

Applicant Signature (if other than retiree) — Date

_____ _____

Spouse Signature – ***REQUIRED*** **if electing the cross-reference payment option** — Date

_____ _____

Retirement Insurance Coordinator Signature — Date

_____ _____

Spouse's Insurance Coordinator Signature – ***REQUIRED*** **if electing the cross-reference payment option** — Date